

**DoD Medical Examination Review Board
8034 Edgerton Drive, Suite 132
USAF Academy, Colorado 80840-2200**

ALLERGIES QUESTIONNAIRE

NAME: _____ SOCIAL SECURITY NUMBER: _____-_____-_____

Please complete all of the questions below regarding history of allergies and return this form to DoDMERB at the above address: Note: If you have been treated for any of the below, please send copies of those treatment records. If more space is needed, please use back of form.

PRIVACY ACT STATEMENT

AUTHORITY: Title 10, USC 133, 3012, 5031, 8013, and Executive Order 9397

PRINCIPAL PURPOSE: To determine medical acceptability or update a medical file as part of the application process to a United States Service Academy, Reserve Officer Training Corp (ROTC) Scholarship Program, or the Uniformed Services University of the Health Sciences (USUHS).

ROUTINE USES: This information may be disclosed to the Coast Guard Academy and Merchant Marine Academy for applicants to their Academies.

DISCLOSURE: Voluntary; however, failure to furnish the requested information will impede the selection process and hamper your candidacy. Use of the Social Security Number (SSN) is used for positive identification of records.

1) Please list your allergies (e.g., allergic rhinitis, hayfever, other allergies, etc.)? _____

2) Please list the frequency and duration of treatment and/or medication used for allergies: _____

3) Do you experience any complications from your allergies? YES NO If yes, please explain (e.g., sinusitis, ear blocks, etc., and treatment for complications) : _____

4) Have you ever had asthma, reactive airway disease, exercise induced bronchospasm, wheezing or shortness of breath? YES NO If yes, please answer 4a, 4b, 4c, 4d, 4e, and 4f below:

4a) Age of onset: _____ **4b) Treatment and/or medication(s):** _____

4c) Have you ever been treated for a breathing problem? YES NO If yes, please explain (emergency room visits, hospitalizations, etc.): _____

4d) Date of last attack: _____ **4e) Date of last medication or treatment:** _____

4f) Frequency of medication used (e.g., daily, weekly, seasonal, prior to athletic/recreational activities, or as needed): _____

5) Have you ever had any past or present skin problems? (e.g., eczema, atopic dermatitis, hives, or urticaria, etc.): YES NO If yes, please explain (condition, treatment and/or medication, and date of last treatment): _____

6) Please describe any contact allergies, (e.g., latex, wool, chemicals, etc.) symptoms, treatment and/or medication(s) and date(s): _____

7) Have you ever had any allergic reactions to foods? YES NO If yes, please explain {symptoms and specific food(s)}: _____

8) Certification: By signing below, I hereby certify that the above information is true and accurate to the best of my knowledge.

Applicant's Signature

Date

Allergies Questionnaire